



STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

**INSTRUCTIONS FOR COMPLETING
THE APPLICATION FOR CHANGE IN AUTHORIZATION**

The following instructions will assist you in completing the application for change in authorization. If additional assistance is required, please contact your Regional Coordinator (visit the OEMS website at www.ct.gov/dph/ems for individual contact information) at the Office of Emergency Medical Services (OEMS) at (860) 509-7975.

General Instructions:

Please type or neatly print information. Write N/A in the space if a question does not apply.

When the application has been completed, mail the original to OEMS. A Copy should be retained for you file.

Please **do not** place the completed application in a binder. Staple once in the upper left-hand corner and place in large envelope.

Page-by-Page Instructions:

- No. 1: Fill in the full official/legal name of your organization.
- No. 2 Fill in the complete mailing address, phone and fax number of your organization.
- No. 3 Fill in the name and title of the contact person and his/her title. The contact person should be whomever you would like us to contact should we have questions regarding the application. It should be someone who knows your organization and is easily accessible during normal working hours. It does not have to be the Chief or EMS officer.
- No.4 Fill in the email and phone numbers for the contact person.
- No. 5 Fill in the **CURRENT** level of certification. This information is provided on your organizations license or certification of operation as an EMS provider.
- No. 6 Indicate the level of authorization your organization is **REQUESTING** from OEMS and your sponsor hospital.
- No. 7 After you fill in your sponsor hospital information **please attach a copy of the protocols and sponsor hospital quality assurance plan for this new level of authorization.** Electronic copies on disc or flash drive are acceptable.

Phone: (860) 509-7975

Telephone Device for the Deaf: (860) 509-7191

410 Capitol Avenue-MS#12EMS

PO Box 340308 Hartford, CT 06134

Affirmative Action/ An Equal Opportunity Employer



Instruction for completing the Application for Change in Authorization

- No. 8 **Attach a list of currently certified personnel trained to the new level of authorization.** This is to include: last name, first name, certification/license number, and expiration date.

If the organization does not yet have sufficient personnel trained to the desired new level of authorization, please state the date the organization expects to meet this requirement. If approved, conditional MIC authorization shall be issued. Final MIC authorization will be contingent upon the EMS organization submitting a roster of personnel authorized at the new level to OEMS within six months along with an attestation from the sponsor hospital EMS medical director that said personnel are eligible for sponsorship at the new level. Upon favorable review, OEMS will then issue MIC authorization to the service.

Sponsor Hospital Agreement:

After you have compiled all the information, and the CEO of your organization has signed the application, the entire application must be reviewed by the sponsor hospital. Submit the entire application and attachments to the EMS Coordinator or Medical Director. **Original signatures** of the EMS Coordinator, Medical Director and Hospital Chief Executive Officer of the sponsoring institution must be present on the application.

EMS Provider Organization Attestation:

The attestation must contain an original signature of the Chief Executive Officer (CEO) of the service.

Completed Application:

When the application and sponsor hospital review has been completed, mail the original application and attachments to: Connecticut Department of Public Health, Office of Emergency Medical Services (see below), and keep one copy for your file.

**Connecticut Department of Public Health
Office of Emergency Medical Services
410 Capitol Avenue, MS #12EMS
P.O. Box 340308
Hartford, CT 06134-0308
(860) 509-7975**



STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

APPLICATION FOR MOBILE INTENSIVE CARE AUTHORIZATION

EMS Organization Information

1. Name of Organization: _____

2. Mailing Address: _____

Phone: _____ Fax: _____

3. Contact Person and Title: _____

4. Contact Person Email: _____

Daytime Phone: _____ Mobile Phone: _____

5. What Levels of License or Certification does your Service **NOW** hold? (Check all that apply)

☐ First Responder ☐ Basic Ambulance ☐ MIC-AEMT ☐ MIC-Paramedic

6. What levels of authorization is your organization **requesting**? (Check all that apply)

☐ MIC-AEMT ☐ MIC-Paramedic

How will you schedule the members of your organization who are trained at this new level to assure 24-hour coverage? _____

What agencies do you have written mutual aide agreements with to assist in providing uninterrupted 24-hour coverage at the requested level? Attach copies of all such agreements. _____

Sponsor Hospital Information and Treatment Protocols

Name of Sponsor Hospital: _____

Address: _____

Medical Director: _____ Phone: _____

E-Mail: _____ Fax: _____

EMS Clinical Coordinator: _____ Phone: _____

E-Mail _____ Fax: _____

(If the mailing address of the Medical Director or EMS Coordinator is different than the Hospital mailing address please include it on an attachment to this form.)

Title of Sponsor Hospital Protocols: _____

Revision Date: _____

Have the Protocols been made available to the authorized staff members of you organization? [☐] Yes [☐] No

Please attach a copy of the protocols and Sponsor Hospital Quality Assurance Plan for this ***new*** level of authorization. Electronic copies are acceptable.

Please attach a list of personnel trained to the new level of authorization, including the following information: last name, first name, certification/license number, and expiration date.

Sponsor Hospital Agreement

The information within this application has been reviewed in its entirety by the following individuals and collectively we, _____ agree to sponsor

(Print name of sponsor hospital)

_____ at the _____

(Print name of EMS organization)

(Specify AEMT or Paramedic)

level of care. We accept the responsibilities described in Connecticut Agency Regulation 19a-179-12.

Hospital Medical Director (Print)

Signature

Date

EMS Coordinator (Print)

Signature

Date

Hospital Chief Executive Officer (Print)

Signature

Date

EMS Organization Attestation

I, _____, _____ of
(Print name of EMS organization CEO) *(Printed CEO title)*

_____, acknowledge that the information
(Print name of EMS organization)

provided within this application is current and accurate. I understand and agree that the approval of this upgrade is contingent upon the continuance of medical direction and compliance with the Regulations of Connecticut State Agencies governing the delivery of emergency medical services.

EMS Organization CEO (Print)

Signature

Date